N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Instructions For Completing the Electronic Claims Submission (ECS) Agreement

Providers who plan to submit claims electronically must agree to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims.

The ECS Agreement is not transferable from one group practice to another, from one owner of a group practice to another or for individual providers affiliated with a group practice moving to another group practice or a solo practice.

Who Needs to Submit an ECS Agreement

1. Currently enrolled individuals who did not elect to submit claims electronically at the time of their initial enrollment must complete and submit an ECS Agreement prior to beginning electronic claims submission.
2. **If you are already filing electronically, it is not necessary to complete this Agreement if you are only changing your clearinghouse or billing agent.**

How to Complete the Form

1. Type or print in black ink.
2. The ECS Agreement cannot be altered; text cannot be highlighted, struck through, or obstructed through the use of correction fluids.
3. The ECS Agreement must be submitted to CSC by mail; ECS Agreements sent by fax are not acceptable.
4. Provider Name
   a. Enter your name.
   b. The provider name entered on the ECS Agreement must match the name on file with the N.C. Medicaid Program (as indicated on your Remittance and Status Report).
   c. If your name has changed, you must submit a correction according to the process outlined on CSC's website at http://www.nctracks.nc.gov/provider/cis.jsp.
   d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.
5. Provider Number

   Enter your Medicaid Provider Number. Payments will be made to this Medicaid Provider Number.
6. Business Site/Physical Address
   a. Enter the physical address for location where services are rendered.
   b. The physical address entered on the ECS Agreement must match the address on file with the N.C. Medicaid Program.
   c. If your physical address has changed, you must submit a correction according to the process outlined on CSC's website at http://www.nctracks.nc.gov/provider/cis.jsp.
   d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.

8. Signature Authorization and Related Information
   a. All signatures must be original.
   b. Signature stamps are not acceptable.
   c. Photocopies are not acceptable.
9. Claims should not be submitted electronically until notification of approval of the ECS Agreement is received from CSC. You must contact the ECS unit at EDS by calling 1-800-688-6696 or 919-851-8888 (option "1" on the voice response menu.) to obtain an authorization/logon number and verify that testing has been successfully completed.

Return the completed ECS Agreement to:

For USPS mail:
North Carolina Medicaid Provider Enrollment
CSC EVC Center
P.O. Box 300020
Raleigh, NC 27622-8020

For Certified/Overnight Mail ONLY:
North Carolina Medicaid Provider Enrollment
CSC EVC Center
2610 Wycliff Road, Suite 102
Raleigh, NC 27607-3073

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

NC Medicaid Provider Enrollment, CSC EVC Center
P.O. Box 300020, Raleigh, NC 27622-8020

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

l. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify the CSC EVC Center in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to CSC prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to CSC. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents. Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.

8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.

9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.

l0. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.

11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.

12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.

13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.

16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Medicaid Provider Name: _____

Medicaid Provider Number: _____

Business Site/Physical Address:

_____

Street

_____

City & State **Zip Code + Four (Last 4 digits required)**

Signature Authorizations and Related Information Required

**** All Information Must Be Entered for the Application to be Processed****

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

_____

Signature of Applicant **Date**

_____

Printed Name and Title

DMA/FISCAL AGENT APPROVAL:

Acceptance Date: _____ **by** _____